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A \$150.00 check or money order must accompany this application.
Submit to: CBADP, 3101 West 41st Street, Suite 205, Sioux Falls, SD 57105

CERTIFICATION TRACK: ___ Academic Track ___ Experience Track

Name: _____

First	Middle	Last	Maiden
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City: _____ State: _____ Zip: _____

Work Phone: _____ Work Fax: _____

Email: _____

Social Security #: _____ Birth date: _____

YOU ARE REQUIRED TO SUBMIT A COPY OF YOUR CURRENT JOB DESCRIPTION

Agency Mailing Address: _____

City: _____ State: _____ Zip: _____

Job Title: _____

Name of CCDC Supervisor: _____

Educational and Academic Data

Official transcripts must be submitted for all education. If you have a college degree, you do not have to send your high school transcript.

High School Attended: _____

Date of Graduation: _____

GED: _____ Date: _____

Where Issued: _____

COLLEGE/UNIVERSITY (List all post secondary institutions attended):

Name of Institution	City, State	Degree(s) Earned	Date Conferred	Major Course of Study

SPECIALIZED EDUCATION DOCUMENTATION:

List all completed specialized educational courses. All courses must equal 3 or more semester credits and earn a "C" grade or higher.

Requirement	Name of College or University	Prefix - Course Number	Name of Course	Credit Hours	Term Taken	Grade
Example	FSU	HS 212	Study of Alcohol	3	Fall '95	B
Intro to Alcohol Use and Abuse						
Intro to Drug Use and Abuse						
Foundations of Individual Counseling						
Alcohol & Drug Group Counseling						
Alcohol & Drug Treatment Continuum						
Professional Ethics for the CD Counselor						
Counseling Families with Alcohol or Other Drug Issues						
Cultural Competency OR Special Populations						
CD-Specific Elective						

Work Experience Documentation

All experience must be specific to alcohol and drug counseling. List all relevant experience, beginning with your current place of employment. Verification must be received for all experience.

Applicant's Name: _____

Agency Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Supervisor: _____

Job Title: _____

Dates of Employment: From _____ To _____

Was the experience Full Time: _____ Part Time: _____ Volunteer: _____

Agency Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Supervisor: _____

Job Title: _____

Dates of Employment: From _____ To _____

Was the experience Full Time: _____ Part Time: _____ Volunteer: _____

Agency Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Supervisor: _____

Job Title: _____

Dates of Employment: From _____ To _____

Was the experience Full Time: _____ Part Time: _____ Volunteer: _____

Work Experience Verification

Applicant: All experience must be verified. Make a copy of this form for each agency where you completed work experience. Complete the top section and send the form to all agencies, employers, internship sites, etc. for verification of all work experience hours.

Applicant's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Job Title: _____

Dates of Employment: From _____ To _____

Was the experience Full Time: _____ Part Time: _____ Volunteer: _____

APPLICANT STOP HERE

THE FOLLOWING MUST BE COMPLETED BY THE AGENCY, EMPLOYER, INTERNSHIP SITE, ETC.

The applicant listed above is applying for certification as a chemical dependency counselor. Please verify the work experience for this individual and return this form directly to the Certification Board for Alcohol and Drug Professionals, 3101 West 41st Street, Suite 205, Sioux Falls, SD 57105. If the above information is not correct, please make changes and place your initials beside the changes.

I hereby attest that the above information is true and correct. This person was involved in the supervised counseling of diagnosed alcohol and drug abuse clients with the majority of their time spent in individual, group and/or family counseling; and, the remaining experience was related to the AODA Counselor Core Functions.

☐ I verify that the required hours of ongoing supervision have been met (i.e. for every ten hours of client contact, there has been a minimum of one hour of supervision between the clinical supervisor and the applicant).

Signature: _____

Name: _____

Name of Agency: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Title: _____

Date: _____

Total **number of hours** of qualifying work experience: _____

Professional Code of Ethics

The Professional Code of Ethics applies equally to all Certified Chemical Dependency Counselors, Certified Prevention Specialists, Trainees, Interns, and individuals in the process of applying for certification. The Certification Board for Alcohol and Drug Professionals (CBADP) believes that all people have rights and responsibilities through every stage of human development. The goal of the CBADP is for addiction professionals to treat everyone with the dignity, honor, and reverence that is fitting to them.

The Professional Code of Ethical Conduct entitles human beings to the physical, social, psychological, spiritual, and emotional care necessary to meet their individual needs. All Certified Professionals, Trainees, and Interns have a responsibility to adhere to the following guiding principles:

1. That I have a total commitment to provide the highest quality of care for those people who seek my professional services.
2. That I will dedicate myself to the best interests of clients and assist them to help themselves.
3. That at all time, I shall maintain a professional relationship with clients.
4. That I will be willing, when I recognize that it is in the best interest of the client, to release or refer them to another program or professional.
5. That I shall adhere to the laws of confidentiality and professional responsibility of all records, materials, and knowledge concerning clients.
6. That I shall not in any way discriminate against clients or other professionals.
7. That I shall respect the rights and views of other professionals and clients.
8. That I shall maintain respect for institutional policies and management functions within agencies and institutions, but I will take the initiative toward improving such policies if it will best serve the interest of clients.
9. That I have a commitment to assess my own personal strengths, limitations, biases, and effectiveness on a continuing basis; that I shall continuously strive for self-improvement and professional growth through further education and/or training.
10. That I have a responsibility for appropriate behavior in all areas of my professional and private life, and to provide a positive role model especially in regard to the personal use of alcohol and other drugs.
11. That I have a responsibility to myself, my clients, and other associates to maintain my physical and mental health.
12. That I respect the client's right to worship or not, according to their conscience and beliefs, and that I will not impose my own beliefs, values, or standards upon them.
13. That I have a professional responsibility to understand and appreciate different cultures for persons whom are or may be in my care or are recipients of my professional services. I will demonstrate sensitivity to cultural differences in my professional practices.
14. That I have a regard for an individual's needs and rights to equal protection and due process under the laws of the State of South Dakota.

Private conduct is a personal matter, except when such conduct compromises the fulfillment of professional responsibilities or may endanger the health or safety of clients who are or may be under my care. As a professional, I have a responsibility to report, whether obvious or perceived, any ethical violations or concerns related to my peers.

I understand and subscribe to the preceding professional code of ethics and understand that any violation of the principles will be grounds for disciplinary action and sanctions.

☐

By checking this box, I hereby attest that I have read and will comply with the 2004 Codes of Ethics and Standards of Practice of the Certification Board for Alcohol and Drug Professionals.

The Codes of Ethics can be viewed and/or printed at: www.dss.sd.gov/behavioralhealthservices/licensingboards. Applicants who have not read the Codes of Ethics and have not checked the box above will not be granted this certification upgrade by the CBADP.

Signature of Professional

Date

Authorization and Release of Information

I hereby attest that I have not been convicted of, plead guilty to, or plead no contest to, any felony, or to any crime involving moral turpitude or like offense, including any crimes of offenses where imposition of sentence was suspended.

I hereby understand that being convicted of, pleading guilty to, or pleading no contest to, any felony or crime of moral turpitude in any state, federal, foreign jurisdiction, tribal, or military court or tribunal must be disclosed to the Certification Board for Alcohol and Drug Professionals (Board), and that this information, or failure to fully disclose this information, may, standing alone, provide sufficient grounds to deny, revoke, suspend, or refuse certification, recertification, trainee recognition, trainee renewal, or student internship status.

I hereby understand that my obligation to disclose whether I have been convicted of, plead guilty to, or plead no contest to, any felony or crime of moral turpitude in any state, federal, foreign jurisdiction, tribal, or military court or tribunal includes any crimes or offenses where imposition of sentence was suspended.

I hereby attest that I am not required to register as a sex offender.

I confirm that I have never had an application denied, had my professional license revoked or suspended, or been sanctioned or disciplined by this or any other certifying or licensing professional board or authority, public or private. If I have had an application denied, had my professional license revoked or suspended, or been sanctioned or disciplined by this or any other certifying or licensing professional board or authority, public or private, I understand that I am required to provide that information to the Board, in writing.

I hereby authorize the Board to release to any agency, facility, organization, or individual any and all information necessary for verification of credentials.

I hereby authorize any agency, facility, organization, or individual contacted by the Board to release any and all information and documents requested and waive any and all confidentiality or privilege provided by state, federal, foreign jurisdictions, tribal, or military statute, law, or rule. I understand that the Board reserves the right to request further information or documentation to evaluate and verify my application, qualifications, education, training, moral character, and professional competence.

I hereby release and hold harmless the Certification Board for Alcohol and Drug Professionals; its Board Members- past, present and future; its attorneys- past, present, and future; its agents, representatives and employees- past, present and future; as well as and any agency, facility, organization, or individual providing information or documents to the Board pursuant to my application.

I hereby understand that failing to provide accurate, full, and complete responses to the questions and requests for information in my application may, in the Board's discretion and judgment, cause it to deny, suspend, or revoke certification, trainee recognition, or student internship status and may result in administrative, civil, or criminal legal action.

I hereby certify that the information contained herein is correct and true, and that I have read and completely understand the Authorization and Release of Information.

Please print your name below as you would like it to appear on your certificate.

Printed name: _____

Signature of Applicant

Date

Statement of Felony Charges

All felony charges must be disclosed to the Certification Board for Alcohol and Drug Professionals. Felony charges include being convicted of, pleading guilty to, or pleading no contest to, any felony or crime of moral turpitude in any state, federal, foreign jurisdiction, tribal, or military court or tribunal and includes any crimes or offenses where imposition of sentence was suspended. Failure to fully disclose this information, may, standing alone, provide sufficient grounds to deny, revoke, suspend, or refuse certification, recertification, trainee recognition, trainee renewal, or student internship status.

I have had felony charges filed against me. Yes _____ No _____

If you answered 'yes', please provide detailed information below:

Date charges were filed: _____

The Disposition:

The Sentence or Fine:

State why you feel this felony charge does not affect your ability to effectively work in the chemical dependency or prevention specialist field:

Signature of Applicant

Date

SUPERVISOR EVALUATION AND RECOMMENDATION

INSTRUCTIONS FOR THE APPLICANT: Give or mail this form directly to your supervisor(s) after you have filled in the bottom portion of this page. If your present supervisor has been supervising you for less than six (6) months, make a copy of this form and provide it to your immediate and past supervisors.

CONFIDENTIAL

Dear Supervisor:

The individual listed below is applying to the Certification Board for Alcohol & Drug Professionals (CBADP) for certification upgrade as a Chemical Dependency Counselor. The information requested here is an essential part of the Board's evaluation of the competence of the applicant and must be on file before the application for upgrade can be processed.

The CBADP believes that your observation will provide a more complete and accurate impression of the knowledge and skills of the applicant than is available from other sources. Your evaluation and recommendation, plus recommendations from other professionals, and the data furnished by the applicant, will be used in determining eligibility for certification upgrade. The process can only be as good as you and the others make it, by careful and truthful reporting.

Please return the completed evaluation DIRECTLY TO:

CBADP
3101 West 41st Street, Suite 205
Sioux Falls, SD 57105

APPLICANT'S NAME: _____ DATE: _____

SUPERVISOR'S NAME: _____

SUPERVISOR'S TITLE & CREDENTIALS: _____

AGENCY NAME: _____

AGENCY ADDRESS: _____

AGENCY PHONE: _____

SUPERVISOR EVALUATION AND RECOMMENDATION (Continued)

APPLICANT'S NAME: _____

The following items represent the skills needed by a Chemical Dependency Counselor. Evaluate the applicant for their abilities in each area. Mark the rating most descriptive of the individual's demonstrated skills. Use N/O (not observed) ONLY if you have never observed nor have any knowledge of the applicant's skill in that area. Please use the following rating scale:

1 – POOR 2 – NEEDS IMPROVEMENT 3 – ACCEPATBLE
4 – GOOD 5 – EXCELLENT

COUNSELOR SKILL AREAS	RATING	N/O
SCREENING: Determining appropriate and timely services for clients with knowledge of his/her problems and their intensity.	1 2 3 4 5	
CLIENT INTAKE: The process of collecting client information for assessment purposes.	1 2 3 4 5	
CLIENT ORIENTATION: Providing clients with general goals, rules, services, rights, etc. of program services.	1 2 3 4 5	
CLIENT ASSESSMENT: Identification and evaluation of information to determine appropriate treatment services.	1 2 3 4 5	
CHEMICAL DEPENDENCY EVALUATION: Knowledge and application of the major theories and stages of addiction and the symptomatology of chemical dependency for assessment of clients.	1 2 3 4 5	
TREATMENT PLANNING: Defining problems and needs, establishing long- and short-term goals and developing a treatment process and the resources to be used.	1 2 3 4 5	
COUNSELING SKILLS: (Individual, Group, Family) The utilization of special skills to assist in assessing client's problems and facilitating appropriate changes.	1 2 3 4 5	
CASE MANAGEMENT: The coordination of services, agencies, resources or people within a planned framework of action for the achievement of established goals.	1 2 3 4 5	
CRISIS INTERVENTION: Assessing, defining and responding to the needs during acute, emotional, and/or physical distress.	1 2 3 4 5	
CLIENT EDUCATION: Provision of information concerning alcohol and other drug abuse implications, available services, and resources.	1 2 3 4 5	
REFERRAL: Identifying and limiting of appropriate services, familiarization of community and state resources available with demonstration of the referral process, including confidentiality requirements.	1 2 3 4 5	
REPORT AND RECORD KEEPING: Charting the results of the assessment and treatment plan, writing reports, progress notes, discharge summaries, and other client-related data.	1 2 3 4 5	
CONSULTATION: Relating with agency staff and other professionals to assure comprehensive, quality care for clients.	1 2 3 4 5	
PROFESSIONAL & ETHICAL RESPONSIBILITIES: A counselor's ability to adhere to generally accepted ethical and behavioral standards of conduct and continuing professional development.	1 2 3 4 5	

SUPERVISOR EVALUATION AND RECOMMENDATION (Continued)

Are you involved in the administration/management of the program where you are employed?

_____ No

_____ Yes, limited to clinical aspects (i.e., supervision of counselors).

_____ Yes, limited to administrative responsibilities.

_____ Yes, both _____ % clinical and _____ % administrative.

How long have you supervised this applicant? _____

For what period of time, while under your supervision, was chemical dependency counseling the major part of this applicant's responsibilities?

From: _____ To: _____

Describe those activities: _____

Comments and/or additional information you feel may be pertinent: _____

I hereby certify that I have been in a position to observe and have first-hand knowledge of the applicant's work at: _____

(Name of work setting)

_____ I recommend this applicant for certification upgrade.

_____ I do not recommend this applicant for certification upgrade.

I hereby certify that all of the above information is, to the best of my knowledge, true.

Signature of Supervisor

Date

Professional Recommendation Form

Provide this form to a professional and/or academic colleague who is acquainted with your chemical dependency counseling experience. Provide a pre-addressed, stamped envelope so the form can be mailed directly to the CBADP Administrative Office.

NOTE: ANY INDIVIDUAL WHO HAS COMPLETED THE 'SUPERVISOR EVALUATION AND RECOMMENDATION' FORM FOR THIS APPLICANT MAY NOT SUBMIT A 'PROFESSIONAL RECOMMENDATION' FORM.

PART I - TO BE COMPLETED BY THE APPLICANT

Complete the information below. Give this form to a professional who is acquainted with your work performance and abilities. Be sure to provide the individual with a pre-addressed, stamped envelope so the form can be mailed directly to the CBADP.

Name of Applicant: _____

Address: _____

City: _____ State: _____ Zip: _____

I understand that this recommendation will be used in determining my eligibility for certification upgrade and is a character reference. Therefore, I agree and understand that I will not be entitled to this information under any circumstance.

Applicant's signature

Date

PART II - TO BE COMPLETED BY A PROFESSIONAL OR ACADEMIC ACQUAINTANCE

The person listed above has applied for certification upgrade as an Alcohol and Drug Counselor. The signature above authorizes you to complete this form. Your assessment will assist the CBADP in determining the applicant's appropriateness for this certification upgrade. A fair and candid report is essential. Therefore, we ask for careful ratings and comments about character and ability. All information submitted will be viewed as confidential and will not be available to the applicant.

YOUR NAME: _____

POSITION/TITLE: _____

BUSINESS ADDRESS: _____

DAYTIME TELEPHONE #: _____

HOW LONG HAVE YOU KNOWN THE APPLICANT: _____

IN WHAT CAPACITY: _____

Professional Recommendation Form (Continued)

Please rate the candidate by circling the most accurate response. Use “Don’t Know” ONLY if you have never observed or have absolutely no knowledge of the respective variable.

COUNSELOR SKILL AREAS	Poor-Excellent	Don’t Know
Breadth of knowledge in alcohol and other drug abuse	1 2 3 4 5	
Breadth of knowledge in the twelve core functions	1 2 3 4 5	
Relationship ability	1 2 3 4 5	
Communication skills	1 2 3 4 5	
Sense of responsibility & adherence to state & federal confidentiality regulations	1 2 3 4 5	
Empathy / understanding	1 2 3 4 5	
Openness / genuineness	1 2 3 4 5	
Honesty / integrity	1 2 3 4 5	
Cooperation with others	1 2 3 4 5	
Ability to recognize and set appropriate limits with clients	1 2 3 4 5	
Self-assessment / insight	1 2 3 4 5	
Ability to be objective	1 2 3 4 5	
Flexibility / adaptability	1 2 3 4 5	
Emotional stability	1 2 3 4 5	
Crisis problem solving	1 2 3 4 5	
Counseling abilities & competencies	1 2 3 4 5	

Please provide a written overall assessment of the candidate as a Counselor. Comment on the intellectual and personal assets and/or liabilities that would affect the person’s professional practice in alcohol and drug abuse counseling.

Signature

Date

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DAYTIME TELEPHONE #: _____

HOW LONG HAVE YOU KNOWN THE APPLICANT: _____

IN WHAT CAPACITY: _____

Professional Recommendation Form (Continued)

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Honesty / integrity	1 2 3 4 5	
Cooperation with others	1 2 3 4 5	
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HOW LONG HAVE YOU KNOWN THE APPLICANT: _____

IN WHAT CAPACITY: _____

Professional Recommendation Form (Continued)

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Signature

Date